Kan Be Healthy
Physician or Health Care Provider Statement of Medical Necessity

Patient Name: _____ Age: _____
SS#: _____ Medicaid #:_____
Diagnosis: _____
_____
_____

As a Physician or other health care provider acting within my scope of practice, I certify that the following services and the amount, duration, and scope of services are medically necessary to correct or ameliorate the conditions discovered by a Kan Be Healthy screen. I request that Kansas Department of Health and Environment arrange for the provision of these medically necessary services: (***put a checkmark next to needed services and write in amount, duration, and scope of service.)***

☑	**Service Needed**	**Amount, Duration & Scope of Service**
	(1) Inpatient hospital services (other than services in an institution for mental diseases);	
	(2) outpatient hospital services,	
	(3) rural health clinic services and any other ambulatory services which are offered by a rural health clinic;	
	(4) federally-qualified health center services;	
	(5) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State	

	plan and who desire such services and supplies;	
	(6) physicians' services furnished by a physician whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere;	
	(7) medical and surgical services furnished by a dentist;	
	(8) other laboratory and X-ray services;	
	(9) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;	
	(10) home health care services;	
	(11) private duty nursing services;	
	(12) dental services;	
	(12) physical therapy and related services;	
	(13) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;	
	(14) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a	

	home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, **for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;**	
	(15) services in an intermediate care facility for the intellectually disabled;	
	(16) inpatient psychiatric hospital services for individuals under age 21;	
	(17) services furnished by a nurse-midwife;	
	(18) hospice care;	
	(19) case-management services;	
	(20) respiratory care services;	
	(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner;	
	(22) **personal care services** furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is	

	qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location;	
	(23) primary care case management services;	
	(24) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary of Health Human Services.	

_____

Physician's Name (or RN, ARNP, or other qualified health care provider acting within their scope of practice)

_____

Address and phone number

Date and Signature:_____

(If the parent, physician, or other treating health care provider of a youth with a disability has any questions about these federally mandated Kan Be Healthy/EPSDT services please call the Disability Rights Center at 1-877-776-1541 or 785-273-9661.)

Items 1 through 48 above are mandatory services based on federal Medicaid Law: 42 U.S.C. §§ 1396d(a)(1-27); 42 C.F.R. §§ 441.50 – 441.62; and 42 C.F.R. §§ 440.1 through 440.185. (Updated November 5, 2013)